**This form is not to be used if your license is in a delinquent or cancelled status.**



State of California Department of Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

**LICENSING PROGRAM**
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.caldocinfo.ca.gov

## *APPLICATION TO RESTORE LICENSE TO FULL, ACTIVE STATUS FROM INACTIVE, DISABLED OR FEE EXEMPT STATUS OR FROM DISABLED STATUS TO ACTIVE STATUS WITH LIMITATIONS ON PRACTICE*

***Please print or type. Illegible applications will be returned.***

FOR OFFICE USE ONLY

Fee Paid: _____ Receipt No.: _____
Date Cashiered: _____ Cashier's Intl: _____
Date Approved: _____ Date Denied: _____

Enforcement Approval: _____Yes _____No Date: _____

| | |
|---|---|
| **Name (first, middle, last):** | |
| **Address of Record:** Current public/mailing address: This is the address that will be displayed on the Internet. If listing a PO Box, you must also provide a confidential street address. | |
| **Telephone Number:** **FAX Number (if applicable):** | Telephone ( ) FAX ( ) |

**Current status of your license**: (Check one box only.)

| | | | |
|---|---|---|---|
| ☐ | Retirement (see Part 1) | ☐ | Inactive (see Part 4) |
| ☐ | Military Service (see Part 2) | ☐ | Disabled (see Part 5) |
| ☐ | Voluntary Services (see Part 3) | | |

| | |
|---|---|
| **Social Security Number:** | |
| **California Medical License Number:** | |

Please note the renewal cycle is based upon your date of birth. Those persons choosing to restore a license to active status during the middle of a renewal cycle, depending upon date of birth, may have a renewal period of less than 24 months.

### Part 1. RETIRED STATUS. *Please provide all information requested below.*

Your license must be current at time of application. A renewal fee is required to restore your license. You are required to submit payment of the current (active license) renewal fee with this application.

To restore your license to "active" status you must document completion of 50 hours of continuing medical education (CME) within the past two years. The documentation of these hours MUST be submitted with this application.

### Part 2. MILITARY STATUS. *Please provide all information requested below.*

If you currently hold a "military" license, a renewal fee is required if you have been discharged from full-time active service or you are still in the military and are canceling your "military" license to restore your license to "active" status. If it has been more than 60 days since your discharge from active service and you have not paid your renewal fees, you will be required to submit payment of any accrued renewal fees, a delinquent fee and a penalty fee. If you hold a current wallet certificate under "Armed Forces Personnel No Private Practice Allowed," it must be returned with this application.

If you checked "military," please indicate which branch of service. (Check one box only.)

☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ U.S. Public Health Service

Have you been granted a continuing medical education (CME) waiver? ☐ No ☐ Yes

If you were granted a waiver, you must document completion of 50 hours of CME within the past two years. The documentation of these hours must be submitted with this application.

Are you still in the military?

☐ No. Please provide dates of service or training:

| From (month/day/year): | To (month/day/year): |
|---|---|
| | |

☐ Yes. Please provide expected date of discharge and/or retirement from active service or full-time training:
Month _____ Day _____ Year _____

**Part 3. VOLUNTARY SERVICES. Please provide all information requested below.**

To restore your license to "active" status you must document completion of 50 hours of CME within the past two years. The documentation of these hours MUST be submitted with this application. Your license must be current at time of application. A fee is required to restore your license. You are required to submit payment of the current (active license) renewal fee. If you hold a current wallet certificate under "Voluntary Service No Payment for Services Allowed," it must be returned with this application.

**Part 4. INACTIVE STATUS. Please provide all information requested below.**

To restore your license to "active" status you must document completion of 50 hours of continuing medical education (CME) within the past two years. The documentation of these hours MUST be submitted with this application. If you hold a current wallet certificate under "No Practice Allowed," it must be returned with this application. If your license is delinquent, you are required to submit payment of any accrued renewal fees, a delinquent fee and penalty fee with this application.

**Part 5. DISABLED STATUS. *Please provide all information requested below.***

Are you applying to restore your license to: (Check one box only)

☐ Active Unrestricted Status

☐ Active Status with Limitations on Practice. Please describe specific practice limitations (e.g., no surgery): _____

_____

Approximate date disability began: _____ Duration of disability: ☐ Temporary ☐ Permanent

Have you been granted a continuing medical education (CME) waiver by the Board? ☐ No ☐ Yes (enter year) _____

**NOTE TO ATTENDING PHYSICIAN:** If "disabled" was checked on this application, the applicant previously submitted an application for "disabled" status to the Medical Board of California, which was approved. The applicant documented the inability to practice medicine due to a disability or illness. The applicant is now requesting to be removed from "disabled" status and to be permitted to practice medicine. Under state law, the applicant must establish to the satisfaction of the Board that the illness or disability no longer exists or does not affect the applicant's ability to practice medicine safely. **As the applicant's attending physician, please provide the information requested below**.

In the space below, please provide a summary of the applicant's case history. If additional space is needed, please include an attachment.

In the space below, please provide a summary of the applicant's current state of health including any changes in his or her health that now enable the applicant to return to the practice of medicine. If additional space is needed, please include an attachment.

Does the applicant's current state of health prevent the applicant from practicing medicine safely? ☐ No ☐ Yes
If yes, please explain in the space below. If additional space is needed, please include an attachment.

If the applicant requires any limitations or has agreed to limit his or her practice, please provide the information requested below:
Applicant's restrictions or limitations. Please describe specific practice limitations (e.g., no surgery).

Attending physician's name/specialty _____ Telephone number _____

Attending physician's address _____ City _____ State _____ Zip _____

**I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including supporting documents, is true and correct and that I am licensed to practice in the United States of America.**

Attending physician's signature _____ Date _____

Attending physician's license number _____ Attending physician's state of licensure _____

**THE FOLLOWING MUST BE COMPLETED BY THE APPLICANT:**

**I certify under penalty of perjury under the laws of the State of California that the information contained in this application, including supporting documents, is true and correct and that I am licensed to practice in the State of California.**

Applicant's signature _____ Date _____

## FINANCIAL INTEREST

| If you have any financial interest to report, please complete the portion below. If not, check box to the right. (Attach additional sheet(s), if necessary.) **Signature is required below**. | | **No** |
|---|---|---|

California's financial interest disclosure law (Business and Professions Code section 2426) requires you to disclose any financial interest that you or your immediate family have in specified health-related facilities located in or outside the State of California. "Immediate family" means a spouse, child or parent of a licensee, and a spouse of a child of a licensee.

Financial interest includes any type of ownership interest including share or stock ownership, limited partnership interest, debt, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

"Health-related facility" means any facility that provides clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, and outpatient surgery centers. Diagnostic imaging includes all x-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) does not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation which has total gross assets exceeding $100,000,000.

| Health-related facility name(s) | Facility's address |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I certify under penalty of perjury under the laws of the Sate of California that I read and understand the information defining financial interest and that either I have disclosed on this application the names of those health-related facilities in which I or my family has a financial interest, or I do not have any financial interest to disclose.

Applicant's signature: _____ Date: _____

*The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals. Agency Name: Medical of California, Licensing Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825; Telephone: (916) 263-2382. The official responsible for information maintenance is the Chief. The authority, which authorizes the maintenance of the information, is the Business and Professions Code. Public Law 9-455(42 U.S.C.A. 405(c)(2)(C)) authorizes collection of your social security number (SSN) and/or federal employer identification number (FEIN).*

*Disclosure of your United States social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c) (2) (c)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.*